Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 8, 2017	2017_620126_0003	004418-17, 004422-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

Long-Term Care Home/Foyer de soins de longue durée

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 23, 24, 27, 28, March 1, and 6, 2017

During this inspection two complaint inspections related to resident's care and services

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Manager(RCM) of registered nursing staff, the RCM of non registered nursing staff, several Registered Nurses (RN), Several Registered Practical Nurses(RPN), several Personal Support Woker (PSW), several residents and a family member.

The following policies were reviewed during this inspection:
Fall Prevention Program: Resident Assessment for Falls Tool (RAFT) #315.08, last reviewed September 2013, Complaints #750.43, last reviewed November 2016, Least Restraint #33.10, last reviewed January 2017, Cleaning of Resident Care Equipment #845.01, last reviewed October 2016. Also, the Roles and Responsibilities for Personal Support Worker (PSW) dated 2015-05 was reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident's #001 Substitute Decision Maker (SDM) send an email to the Ministry of Health on February 20, 2017 expressing several concerns related to resident's #001 care.

Resident #001 was admitted to the home in 2009, with several diagnosis.Resident requires assistance and mobilize herself/himself in a wheel chair (W/C) with a front closure seat belt. At meal time, resident # 001 requires some supervision, but can eat well sandwiches and finger food independently with minimal assistance. Resident #001 is incontinent and requires assistance to be toileted.

Resident #001 health care record was reviewed by Inspector # 126 over several days. It was noted that the interventions for resident #001 does not set out clear directions.

A care conference was done with the SDM in December 2016, following the fall of

resident #001 two days prior to to the conference. It is documented in resident #001's progress notes that the resident should:
1) ensure resident #001 is one of the first resident to be assisted to get up in the morning and to be toileted,
2) ensure resident #001 is being toileted at least twice a shift, even during the night shift at the beginning and at the end of the shift,
3) ensure that when resident #001 is in bed, the bed should be at the lowest with a rubber mat beside the bed. The head of the bed should me maintained at 30 degrees,
4) ensure the call bell is attached to resident #001's clothes to ensure that when he/she get up the call bell will ring
5) ensure resident #001 has a front closure seat belt on when sitting in the wheelchair (w/c) and ensure it is attached.
6) ensure resident #001 sit in the w/c in the morning if feeling well and to have a nap in the afternoon
7) ensure resident #001 shoes are to be left on the seat of the w/c when resting in bed.

The plan of care was reviewed by RN #100 on that same day for falls and positioning and was updated in February 2017 for the Activity of Daily Living. All above information discussed at the conference was in updated plan of care.

Resident #001's current kardex dated March 14, 2016 was reviewed. It was noted that there was some changes in interventions which were documented but not dated. The interventions related to December 2016, Care Conference were not documented on the kardex, such as being one of the first resident to be assisted up and toileted in the morning, toileting requirement of twice a shift with assistance, the purpose of the call bell attached to her/his clothes, having the front closure seat belt when sitting in the w/c, napping in the afternoon and to put the resident's shoes on the seat of the w/c while he/she is resting in bed.

The night shift assignation sheet (not dated) was reviewed and it was documented that resident's #001 was independent and did not have any restraint. No documentation was found related to toileting resident #001 twice a shift even during the night (beginning and at the end of the shift), the position of the bed (lowest, head at 30 degrees), the rubber mat, the call bed and the restraint if resident is sitting in the w/c.

Discussion held with RN #100 indicated that the nursing staff need to manually update all information on the care plan tools and that the kardex and the residents night assignation sheet were not updated after December 2016 care conference.

The plan of care does not set out clear directions to staff and others who provide direct care to the resident #001. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the care plan reviewed and revised when the resident's care needs change.

During this complaint inspection, Inspector #126 reviewed resident #001's health care record. It was noted in the progress notes on a specific date of December 2016, by RPN #104, that resident #001 was observed to have a small blood clot (size of a pea) in her incontinence brief. Also, RPN #104 observed resident #001 voiding hematuria in the toilet. There was no other notes or interventions documented in the progress notes related to the presence of blood until 18 days later when the Substitute Decision Maker (SDM) informed RN #103, that she observed the presence of a blood stain in the incontinent product of resident #001.

The "Daily 24 hours Report Book" was reviewed. It was noted in the book, on that specific date in December 2016, on evening shift, the observation related to the small blood clot. The following day, on the three shifts (day, night and evening), it was noted that resident #001 did not have any hematuria on those three shifts. There was no documentation related to the monitoring of blood clot and or the hematuria, until 18 days later when the SDM notified RN #103 of her observation. The physician was contacted and blood work was ordered. A urine culture was collected two days after it was reported by the SDM and the urine culture came back positive for a urinary track infection.

In a telephone interview on March 6, 2017, RPN #104, indicated to Inspector #126 that she documented the progress notes on that specific date in December 2016 and after she wrote a note in the "Daily 24 hours Report Book" for monitoring and that she notified RN #105.

In a telephone interview on March 6, 2017, RN #105, indicated to Inspector #126 that she cannot recall specifically the incident of that specific date in December 2016. RN #105 indicated that usually, with observation of the presence of hematuria, the nursing staff would check the urine and check if the resident is on anticoagulant. RN #105 indicated that there should have been documentation of the assessment was completed.

RPN #104, indicated that monitoring of the hematuria was the intervention in place on the next day the blood clot/hematuria was initially observed and that the physician was

not notified. The plan of care was not updated to ensure the changes in the resident's condition. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care set out clear direction to staff and others who provide direct care to the resident and to ensure resident # 001 is assessed when there is change in condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; that the policy is complied with.

The licensee policy "Least Restraint" No.335.10 last reviewed January 2017 was reviewed by Inspector #126. The Procedure under initiation of restraint requires:
"1. Complete an assessment to determine rational e for considering a restraint. Potential for injury to self or others.
2. Ensure all possible alternative interventions are attempted prior to applying a restraint (see Decision Tree).
5. Obtain and document consent or refusal on consent form.
7. Fax the Physician Order to Pharmacy so that the restraint order will appear on the MAR and the Quarterly Medication Review.

9. Initiate the Restraint Monitoring Form. Ensure completion using the appropriate key and response.
18. The resident's condition is reassessed and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff and documented on the MAR"

On March 2, 2017, Resident Care Manager(RCM) for registered nursing staff, indicated to Inspector #126 that the home has a new revised January 2017 "Least Restraint Policy" and that it is expected that the nursing staff implement and comply with the newly revised policy.

Resident #001, #002, #003, #004 and #005's health care records were reviewed by Inspector #126 on March 2, 2017 and the following were noted:

Resident #001 assessment, Physician order was not faxed to the pharmacy and the restraint order for front closure lap belt was not documented on the Medication Administration Record(MAR), the documentation of the monitoring by the Personal Support Worker (PSW) and by the Registered Nursing staff was not completed as required by the policy.

Resident #002, #003, #004, #005's did not have monitoring sheet for the PSW and the registered nursing staff. Resident #003's consent for restraint was dated 2015. The Physician order was not faxed to the pharmacy and the restraint order for front closure lap belt was not documented on the Medication Administration Record(MAR), the documentation of the monitoring by the Personal Support Worker (PSW) and by the Registered Nursing staff was not completed as required by the policy.

On March 2, 2017, RN #100, indicated to Inspector #126 that the Physician Order for resident's #001's restraint for front closure lap belt was not fax and documented in the MAR. She further indicated that the registered nursing staff were observing resident #001 every shift but that it was not documented and that the PSW were not documenting hourly. RN#100 indicated that she was not aware of that requirement.

On March 2, 2017, RN #106, indicated to Inspector #126 that PSWs were supposed to be monitoring the residents with restraint on an hourly basis and they were supposed to be signing off the monitoring sheet. Also, RN #106, was not aware of the requirement for the registered nursing staff to be signing every 8 hours.

On March 2, 2017, RPN 107, indicated to Inspector #126, that she was not documenting the shift assessment and that she was not aware about the hourly monitoring sheet for restraint application for residents. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff comply with the "Least Restraint Policy" for all residents of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately notify the Director of an incident of improper care and treatment that resulted in an injury.

On a specific date in September 2014, resident #001 received a bath in the tub room. Resident stood up and fell and had an injury. Resident #001 was sent to the hospital and came back the same day. The licensee initiated an investigation with the PSW that was in the tub room with the resident at that time. It was determined that the PSW did not applied the seat belt when resident was sitting in the tub chair and when she turned her back, resident # 001 got up and fell. The PSW involved in the incident was disciplined by the licensee.

In an interview held with the Administrator on February 28, 2017, she indicated to Inspector #126 that the investigation was immediately initiated and that the PSW involved in the incident was disciplined. The Administrator could not locate a critical incident for that incident.

As of February 28, 2017, the licensee has not notified the Director of this incident of improper care and treatment that resulted in an injury. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was admitted to the home in January 2009, with several diagnosis.

Resident #001's Medication Administration Record Sheet (MARS) dated July 2016 was reviewed by Inspector #126 and indicated that resident requires a medicated patch to be applied daily on her/his back, On several occasions, resident #001 was observed to be removing the medicated patch by scratching the patch specially when the patch was applied on an area that was accessible to her/him.

On a specific date in July 2016, resident #001's Substitute Decision Maker (SDM) was visiting and noted that resident #001 did not have the medicated patch on the back. The SDM informed RN #100 who assessed resident #001 and did not find the medicated patch anywhere on resident's body. At that time, RN #100 reapplied a medicated patch on the back of resident. Later that day, RN #100 interviewed RN #102 (RN who applied the patch that morning), indicated that she had applied the medicated patch that specific morning of July 2016 on the front of the resident not on the back.

RN # 102 did not administer the medication as specified by the prescriber. [s. 131. (2)]

Issued on this 8th day of March, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.